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POLICY REVIEW

HEALTH STRATEGY FOR UNICEF

SUMMARY

The present report has been prepared in response to Executive Board decision 1992/22 (E/ICEF/1992/14), which requested UNICEF to elaborate further on its health strategy in the context of community-focused health sector development. The report also responds to guidance provided by delegations to the Board (see E/1994/34, E/ICEF/1994/13, paragraphs 466-477), follows a process of consultation with countries and major international partners of UNICEF in health, and reflects the findings of the 1992 multi-donor evaluation of UNICEF in the health and nutrition sectors.

Improving the health and nutrition of the world's children has been a principal objective of UNICEF throughout its history. The past two decades have provided valuable lessons which serve as the basis for the present UNICEF health strategy. These include the importance of multisectoral social mobilization in achieving time-bound goals around which technical and political consensus has been reached; the importance of taking programme actions to scale; and the critical role that frequent and visible monitoring at multiple levels plays in sustaining health partnerships and action.

The reduction of infant, child and maternal mortality are the overarching goals of UNICEF in health. The actions of the World Health Assembly provide the policy framework in which these and supporting goals are pursued. The role of UNICEF has been to operationalize and advance those World Health Assembly policies of greatest significance to the health and well-being of children.

The UNICEF approach to health places the family and the household at the centre of health action and the child at the centre of the household. It is guided by the Plan of Action of the World Summit for Children and the Convention on the Rights of the Child, which stipulates the obligations of States Parties and of parents to provide access to information, education and essential services for children so that they may enjoy the highest attainable

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standard of health. UNICEF contributes to this by helping to strengthen health monitoring, health promotion and essential health services. The present report discusses how these strategies are adapted and applied in diverse situations from the household to the global levels and in country situations ranging from states of emergency to those with strong economies and functioning health services.

The implications for UNICEF of the proposed health strategy are described in terms of programme action, technical support needs and operations. These implications include significant refinements in situation analyses, strengthened information capacities required to guide programming and partnership processes, a substantially increased emphasis on technical partnerships with the World Health Organization and other international and bilateral agencies, and increased flexibility in supply and financial operations to better service programme objectives.

A draft recommendation for Executive Board approval is contained in paragraph 134 of the present report.

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I. BACKGROUND

1. In its decision 1992/22 (E/ICEF/1992/14), the Executive Board requested UNICEF to elaborate further on its health strategy in the context of community-focused health sector development. An initial report (E/ICEF/1994/L.6) was prepared and discussed at the third regular session of 1994. The present report responds to guidance provided by Board delegations at that session (see E/1994/34, E/ICEF/1994/13, paragraphs 466-477), and follows a process of consultations with countries and major international partners of UNICEF in health.

2. The present report is part of a recent series of strategy papers, the first of which was on nutrition (E/ICEF/1990/L.6), followed by reviews on primary environmental care (E/ICEF/1993/L.2) and gender and development (E/ICEF/1994/L.5 and Add.1). A number of reports on more specific health issues have been reviewed by the Executive Board in recent years (see annex I). A separate report on UNICEF follow-up to the International Conference on Population and Development (ICPD) (E/ICEF/1995/12) also is being submitted to the Executive Board at the present session. Policy reviews addressing UNICEF strategies for the water and environmental sanitation and the education sectors will be submitted to the Executive Board at its 1995 annual session. Taken together, these complementary programme strategies will guide UNICEF in the 1990s and beyond.

3. Remarkable progress has been made in the reduction of child mortality in the past 30 years. In developing countries, infant and child mortality fell by an average of 2 per cent per year in the 1960s, by over 3 per cent in the 1970s and by over 5 per cent in the 1980s. The decline, however, was slowest in sub-Saharan Africa. For the developing countries as a whole, total child deaths (0-4 years of age) stood at approximately 13 million in 1990 compared to 15 million in 1980. Allowing for population growth, this is a reduction of some 5 million in the number of children who would have died in 1990 if the 1980 under-five mortality rate had still prevailed.

4. Despite such progress, however, disease and ill-health remain widespread. The 1993 World Development Report cited World Health Organization (WHO) and World Bank estimates of the "global burden of disease", which is calculated by adding up disability adjusted life years (DALY) in terms of years of productive life lost owing to premature death and disability. In 1990, 1.36 billion DALYs were lost worldwide - the equivalent of 42 million deaths of newborn children. The burden was especially heavy for sub-Saharan Africa, with 575 DALYs per 1,000 people, which was more than double the world average of 259.

5. Demographic and epidemiological transitions taking place in developing countries are bringing new health challenges to the forefront. Non-communicable diseases and health problems arising from substance abuse, violence, accidents and environmental hazards are becoming major health problems in large segments of the population in a growing number of developing countries. For example, by the year 2005, deaths attributable to smoking in developing countries and countries in transition are expected to be double the 1990 figure of 1.7 million. The menace of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) is an unprecedented danger to children's and women's health that threatens to reverse the progress made in the last decades. A new focus on young women and adolescents entering reproductive age is needed now to combat the AIDS pandemic as well as the effects of growing substance abuse and violence. Rapidly increasing urban poverty and squalor and the degradation of the living environment pose a new level of health threats to rising numbers. Different priorities and strategies have to be applied to diverse situations ranging from where the "old" causes of children's deaths and ill-health dominate to where the newer problems have become more significant.

A. Global health partners

6. Throughout the developing world, countries are supported in their efforts to improve maternal and child health (MCH) by an alliance of many organizations active in health. UNICEF support within the health sector is a small but strategic component of this global effort. It is focused on increasing political will, building multisectoral partnership and mobilizing communities and societies in addressing child and maternal health. 1/ This global partnership includes WHO, the World Bank, the United Nations Population Fund (UNFPA), the United Nations Development Programme (UNDP) and UNICEF, as well as bilateral development organizations and regional banks, international and national foundations and non-governmental organizations (NGOs). In addition to providing financial assistance, these development partners influence policies and priorities by bringing international experience to national efforts, supporting the transfer of skills and technologies, and promoting catalytic activities.

7. WHO has the overall leadership role in setting technical and policy norms in the health sector and is a vital partner for UNICEF in the development of its health policy. UNICEF actions in the health sector are guided by broad policy directives promulgated by the World Health Assembly which relate most directly to the health of children. WHO has lead responsibility within the United Nations system for the coordination of international health work and plays an important role in biomedical research and the development of technical guidelines. In all health programme areas in which it is involved, UNICEF relies on WHO for authoritative technical guidance, as well as an increasingly operational partnership in programme design, monitoring and evaluation. The two agencies enjoy a close working relationship at global, regional and country levels. The UNICEF/WHO Joint Committee on Health Policy guides the policy development of the two agencies at the global level.

8. UNFPA is a longstanding partner of UNICEF in the area of MCH and family planning. The outcome of ICPD offers even greater opportunities for collaboration between UNFPA and UNICEF as it highlighted the need to view family planning in the broader context of reproductive health, with particular attention to women and adolescents. ICPD recognized that sustainable population growth rates can only be achieved through holistic, human-focused development and, in particular, through the empowerment of women and the provision of primary health care (PHC) and basic education, all of which are central UNICEF concerns.

9. With its human development focus, UNDP is an important member of the global health partnership and contributes to a number of specific initiatives such as the Children's Vaccine Initiative (CVI), safe motherhood and the United Nations joint and co-sponsored programme on HIV/AIDS. At the country level, it plays a critical coordination role in supporting the United Nations resident coordinator system and, often, in leading work on the "country strategy note", in which UNICEF also participates.

10. The World Bank is the largest external financier in the health sector. Along with the regional development banks, it plays a major role in influencing health policy and health sector investment, providing guidance in the redirection of public expenditure and mobilizing adequate national resources for priority health objectives.

1/ Notwithstanding important distinctions, for the purposes of this discussion nutrition is encompassed within health.

11. Bilateral donor organizations contribute significantly to health and health sector development both directly and through multilateral channels, including UNICEF, and are important partners for long-term cooperation. They play an important role in mobilizing national technical capacities and making them available to international development partners.

12. NGOs are also long-standing global health partners, both at national and international levels. In most countries, national and local NGOs are important partners in advocating for children and women, promoting health and providing essential health services. Many international NGOs are active in child health initiatives and have become increasingly important partners for UNICEF in recent years.

B. Financial resources for health

13. Every society is struggling between the desire to have access to a growing array of modern medical technology, the moral imperative to provide universal access to services and the reality of limited resources. The UNICEF health strategy is formulated in the light of this search for quality, equity and cost-effectiveness as well as in the realism of existing financial resource allocations for health. According to the 1993 World Development Report: Investing in Health, estimated total expenditure on health in developing countries in 1990 was some $170 billion; of this, external assistance accounted for $4.8 billion, comprising only 3 per cent of total developing country health expenditures. On a per capita basis, developing countries spend an average of approximately $40 per year on health, $1 of which comes from external sources. However, this global average obscures important regional differences. In contrast to the 3 per cent global average, external aid to the health sector in sub-Saharan Africa (excluding South Africa) during 1990 comprised an average of 20 per cent, and in several countries as much as one half of all health expenditures.

14. Total external aid to the health sector as a proportion of total official development assistance declined from 7 per cent during 1981-1985 to 6 per cent during 1986-1990. The estimates of external aid to health in 1990 are shown in table 1 below.

Table 1. External assistance to health, 1990

	Millions of United States dollars	Percentage
Bilateral agencies	1 913	40.0
Development banks	382	8.0
United Nations agencies (other than UNICEF)	1 350	28.0
UNICEF	251	5.0
Non-governmental organizations	830	17.5
Foundations	68	1.5
Total	4 794	100.0

Source: World Bank 1993, World Development Report: Investing in Health.

15. Much of the external assistance is not spent to meet the high priority health needs of children and women; in fact, disproportionate amounts are earmarked for hospital construction and high-tech equipment. There is clearly a case for shifting priorities in external assistance for health as well as for increasing the amount. In this connection, the 20/20 approach (at least 20 per cent of the national budget and at least the same ratio of external assistance being devoted to essential basic services, including PHC) is relevant for assessing and ensuring the adequacy of resources for health. UNICEF expenditure in health, shown in table 2 below, falls mostly in the 20/20 categories. The fluctuation in amounts in the 1990s is due largely to emergencies.

Table 2. UNICEF expenditure in health and nutrition

(In millions of United States dollars)

	1986	1990	1991	1992	1993
Health	119	251	202	228	210
Nutrition	17	29	31	32	31
Total	136	280	233	260	241

C. The child survival and development revolution, the World Summit for Children and the Convention on the Rights of the Child

16. Since 1978, when WHO and UNICEF co-sponsored the International Conference on Primary Health Care, held at Alma-Ata, UNICEF has been increasingly more active in forging working partnerships with national Governments and other global health partners to develop and implement strategies to improve the health of children and women. During the early 1980s, UNICEF took the lead in mobilizing the international community around a strategic set of low-cost, high-impact actions aimed at reducing the preventable deaths of children, which in 1980 amounted to 15 million. This ambitious endeavour came to be known as the child survival and development revolution (CSDR). Building on societies' sense of moral responsibility for their children, CSDR helped to mobilize political will, used communication and social mobilization to raise awareness of child health problems and introduced proven technical interventions to address them on a wide scale. CSDR efforts to promote growth monitoring, oral rehydration, breast-feeding, immunization, family spacing and food security (GOBI-FF) became a cornerstone of UNICEF work in the health sector. Female education was soon added to the CSDR priorities.

17. By the mid-1980s, universal child immunization (UCI) became the lead activity in UNICEF health programmes. The achievements of UCI helped to revitalize PHC through awareness- and demand-creation, community outreach, multisectoral social mobilization and the engagement of high-level political support. UCI and other focused child survival interventions also helped to draw further attention to issues of sustainability, at national and community levels, and to the need to address many of the health needs of children from a solid base of viable health services. The Bamako Initiative, launched in Africa in 1987, was one important response to help revitalize PHC services through greater community involvement in the management and control of resources. With the worsening of the AIDS epidemic in the late 1980s and its stark impact on child mortality in many countries, UNICEF has been expanding its support to activities in the area of reproductive health, with a particular focus on youth.

18. The World Summit for Children in 1990 was a significant milestone in the development of the UNICEF approach to health. It followed a two-year process of priority-setting and consensus-building based on national and regional forums and global-level technical consultations among national, United Nations, international and bilateral technical agencies. This process, in turn, was built on a decade of efforts to strengthen epidemiologic capacities throughout the developing world, enabling improved assessment and monitoring of health status.

19. Emboldened in part by the dramatic progress of global immunization efforts, the international technical community identified a strategic set of technically achievable goals and targets in the health, nutrition, education and water supply and sanitation fields. Taken together, the goals encompassed the range of basic needs and charted a course for human development through the end of the decade. The cumulative impact of these multisectoral efforts envisages a dramatic reduction in infant, child and maternal mortality. These "overarching goals" of reducing infant and child mortality by at least one third and maternal mortality by 50 per cent are central to the development of the present UNICEF health strategy. Prior to the World Summit for Children, the common health goals for the year 2000 were established by the World Health Assembly and endorsed by the UNICEF and WHO Executive Boards, major technical bodies and professional associations throughout the world. At the World Summit, they received the unequivocal endorsement of nearly 150 countries at the highest political level. Subsequently, UNICEF was charged by the United Nations General Assembly with key responsibility for follow-up and monitoring of the implementation of the World Summit for Children Plan of Action.

20. With its central focus on significant reductions in maternal and child mortality, the World Summit Plan of Action required a broadening of UNICEF objectives in its assistance to Governments and a further refinement of its strategies. As the number of MCH commitments has increased, so has the need to rationalize strategies and increase the focus on the common antecedents and underlying causes of poor health among children, youth and women. The coming into force of the Convention on the Rights of the Child has helped to stimulate and guide that reshaping. The Convention both articulates the right of children to enjoy the highest attainable standard of health and stipulates actions, including access to information, education and essential services, required to achieve that right. Included within the Convention are important provisions which recognize the intergenerational factors affecting health, the primacy of the role of parents and families in guiding child development and the responsibilities of Government in supporting families in their efforts.

21. As envisaged in the World Summit Plan of Action, over 100 countries have prepared national programmes of action (NPAs), which include country-specific national goals and strategies based on the World Summit goals. A large number of countries also are taking steps to prepare implementation plans at provincial, district and municipal levels. The NPAs have served in many instances as the basis for a dynamic ongoing process of preparing implementation plans, setting new priorities and targets in changing circumstances, and monitoring progress.

22. A series of mid-decade goals to be achieved by 1995 were agreed upon to build a strong foundation for the achievement of the year 2000 goals. The pursuit of these mid-decade goals has given confidence and has provided valuable lessons for action by countries, UNICEF and other partners in the second half of the 1990s and beyond.

D. UNICEF lessons learned

23. UNICEF strategies in health have continued to evolve through experience and continuing efforts to seek greater effectiveness in its programmes of cooperation. The experience of the past decade points to a number of lessons that remain valid for the future:

(a) Setting clear goals and objectives. A result-oriented approach with specific targets and outcomes has been the key to the progress made in CSDR efforts. Working towards specific programme objectives has required painstaking on-the-ground work of defining target populations, accurately specifying inputs, solving difficult logistical problems, monitoring results and providing feedback to decision makers. In many countries, this has helped health workers gain confidence and apply performance criteria in their work, raising the efficiency of the health system;

(b) Political commitment and social mobilization. A key lesson of the 1980s is the great degree to which progress in health depends on action outside of the health sector. The personal involvement of national leaders in defining goals, reviewing progress and mobilizing public support has been critical to placing child health priorities high on the political agenda;

(c) Action on a national scale. When critical problems affecting large portions of the population are confronted, the measures adopted have to make a significant difference on a large scale. Going to scale with action helps to create its own momentum, builds further demand for action and helps to address issues of equity;

(d) Key role of monitoring. Frequent and regular monitoring at local, intermediate and national levels is a critical element in result-oriented programmes. When community and political leadership participate in this process, it becomes an important tool for political mobilization and public accountability;

(e) Attention to sustainability. Moving towards self-reliance and long-term sustainability must be a major design consideration in goal-driven programmes. This must include provisions for political, financial, institutional and technological sustainability, with appropriate emphasis on developing the national skills and technical capacities required for the longer term. This is especially important for programmes that receive substantial external support;

(f) National capacity-building: strengthening systems in pursuit of goals. Systems that do not deliver results on a significant scale often become part of the problem rather than the solution to promoting health for all. Conversely, short-term, time-bound targets pursued in ways that ignore factors critical to sustainability and capacity-building often undermine the viability of the institutions and processes necessary for self-reliance. To be effective, programmes that address specific health goals should be designed and implemented in ways that contribute to the strengthening of the PHC system, and the effectiveness of the health systems should be judged by the achievement and sustainability of measurable goals in significant scale;

(g) Promoting healthy behaviour and a more proactive approach to addressing health needs. This requires a continuing emphasis on strengthening the capacities of communities, families and individuals to make informed health decisions and to act on them;

(h) Evaluation and operations research. In order to adapt programme efforts to changing circumstances and for more effective action, greater insights are required on how to promote equity, sustainability, quality and universal access to essential information and services. Continuous monitoring,

periodic evaluation and supportive operations research must be essential complements to improved programme implementation;

(i) Flexibility in providing support. This is a critical factor in helping to assure achievement of objectives by enabling mid-course corrections required to capitalize on unanticipated opportunities and to respond to unforeseen difficulties.

II. CONCEPTUAL OVERVIEW

24. The health of a child cannot be addressed in isolation. The family is both the immediate environment of the young child and the child's principal caregiver. The health, behaviour, education and socio-economic status of parents - before, during and after pregnancy - have a powerful influence on the health and development of the child. For these reasons, UNICEF views the family and the household as the centre of health action and the child as the centre of the household.

25. The most important decisions affecting preventable morbidity and mortality among children are those decisions taken in the household. It is in the household where the importance of hand-washing, breast-feeding and the use of oral rehydration therapy (ORT) must be understood and practised. The timely use of health care services, the adoption of behaviour that prevents the transmission of HIV/AIDS and other sexually transmitted diseases (STDs) and enables family planning, the adoption of appropriate feeding practices and the improvement of household and community physical environment all require a greater knowledge of health at the household level and the motivation and resources to act.

26. Fathers, mothers, older siblings, children and other household members each have particular roles in improving family health. Heads of households have a critical role in establishing health as a household priority, in ensuring that adequate resources are allocated to address family health priorities and in continuously monitoring their family's health. Women generally function as the principal providers of home health care for the entire family and the most frequent interlocutors with the health system. Youth often play a transitional role within the family. As older siblings, they play an important role as caregivers and role models for younger children. As young adults, they are beginning to make independent decisions about their own health and are in the process of forming lasting attitudes and adopting behaviour that will influence directly their health and the health of their future children. Finally, children themselves, especially those attending school, often serve as health advocates and educators on basic health issues within the family.

27. UNICEF views health empowerment as the ability to make informed health decisions and to act on them. The more motivated and informed members of a family are, the more likely they are to make the best choices from among the health behaviour, disease prevention and treatment options available to them. Because women play such a central role in household health, their active participation in health sector decision-making processes is particularly critical to their own health and the health of their families. Promoting the rights and improving the status of women in society will enhance their ability to make informed decisions regarding health and to take action.

28. Key determinants of morbidity and mortality can be classified as immediate, underlying and basic socio-economic causes as described by the conceptual framework of the UNICEF nutrition strategy (E/ICEF/1990/L.6). Immediate causes include specific diseases, inadequate dietary intake and injuries. Underlying causes include the lack of essential health services,

insufficient household food security and unhealthy behaviour and practices. 2/ Basic socio-economic causes include limited resources, restrictive social conditions, political factors and unhealthy physical environments. Good health results from effective health-related behaviour influenced by social determinants and environmental factors as well as interaction with an appropriate health system. Consequently, factors outside the health sector are as critical as those within the sector.

29. Beyond the health sector, important factors which influence the capacity for household action in health include political and social organization, physical environment and social and economic status. One of the most significant factors is the political priority attributed to the status of children, youth and women within a given setting. The greater the value placed on their health and development, the more likely steps will be taken towards healthier practices.

30. Social and economic status ares perhaps the most difficult factors to address and yet among the most critical in determining health. Obviously, poverty has an impact on health, although enlightened national health policies and family values and practices make it possible to have good health even in the presence of relative poverty. Poverty alleviation strategies that seek to raise family income as well as to improve basic social services tend to be especially effective in improving health in a sustainable manner. Socially separating features such as caste, religion, tribe and even geographic location are important determinants of health. The lack of progress in social factors is a serious barrier to improving health status.

31. Political and social organizations also substantially determine the capacity for individual and collective health decision-making, both in terms of who participates and how informed and equitable decision-making is. The way in which a community is organized and the extent to which the public sector serves as an agent of equity affects the options that are available to families. Household health options also are affected by societal attitudes towards vulnerable groups and the extent to which these groups are organized and can impact on the political process.

32. Physical environment is a powerful determinant of health. Access to adequate water, sanitation, arable land and clean air, coupled with sustainable management of natural resources, affect people's ability to achieve and maintain good health.

33. Through its partnership with Governments, UNICEF addresses the basic socio-economic causes of poor health on a multisectoral basis. With its direct programme interventions, UNICEF provides support to extend universal primary education, expand the availability of potable water supplies and improve primary environmental care and access to resources, which can contribute to household food security. Through its advocacy, UNICEF raises awareness about the situation of children, reinforces political will for action, influences policies and helps to establish a moral environment that puts the well-being of children high on the political agenda.

2/ For the purpose of this discussion, inadequate maternal and child care, described in the nutrition strategy as an underlying cause, is encompassed within "unhealthy behaviour and practices".

III. OPERATIONAL FRAMEWORK FOR HEALTH SECTOR ACTION

34. Within the health sector, the overarching goals shared by countries and global health partners are to reduce infant, child and maternal mortality. UNICEF also is placing increasing emphasis on the health of youth and women, which is both important in its own right and critical to achieving the child and maternal mortality reduction goals in an increasing number of countries. Achievement of the health goals requires that Governments direct support to partners at national, district and community levels with the aim of increasing household capacity for health actions. UNICEF efforts to promote and protect health address a series of problems. Epidemiologically, the importance of these health problems depends upon their relative contribution to the disease burden of children, youth and women. Operationally, the ranking of priority health problems in each country is dependent on the combination of epidemiologic importance and the responsiveness to technically feasible and socially practical interventions.

Figure I

DISTRIBUTION OF THE DISEASE BURDEN IN DEVELOPING COUNTRIES, 1990: PRIORITY HEALTH PROBLEMS THAT CAN BE ADDRESSED WITH COST-EFFECTIVE INTERVENTIONS

Children under 5 years of age	Children 5-14 years of age	Women 15-44 years of age
1. Perinatal problems 2. Respiratory infections 3. Diarrhoeal diseases 4. Vaccine-preventable diseases 5. Malaria 6. Vitamin A deficiency 7. Protein-energy malnutrition 8. Iodine deficiency	1. Intestinal helminths 2. Vaccine-preventable diseases 3. Respiratory infections 4. Diarrhoeal diseases 5. Tuberculosis 6. Malaria 7. Anaemia 8. STDs	1. Maternal risk 2. STDs 3. Tuberculosis 4. HIV 5. Respiratory infections 6. Anaemia

Source: Adapted from charts on the distribution of the disease burden showing the 10 main causes; 1993 World Development Report: Investing in Health.

35. Notwithstanding regional and local differences in many developing countries, approximately 70 per cent of preventable mortality in children under five years of age, or about 9 million deaths annually, are due to six immediate causes, including acute respiratory infections (ARI), perinatal problems, diarrhoeal diseases, measles, malaria and malnutrition. Along with preventable STDs and complications of early pregnancy, these are also among the major causes of morbidity and mortality of youth. As countries make progress in child health, perinatal problems, many of which are best addressed in young people prior to pregnancy, account for an increasing percentage of infant mortality (see figure I above). Similarly, the substantial majority of maternal deaths can be attributed to five principal immediate causes which include haemorrhage, sepsis, complications of abortion, hypertensive disorders of pregnancy and obstructed labour. These major immediate causes of child and maternal mortality must necessarily be at the top of UNICEF priorities.

36. UNICEF remains committed to assisting Governments in their efforts to address the major causes of morbidity and mortality among children and mothers. A number of specific interventions were highlighted in the World Summit for Children Plan of Action, including breast-feeding promotion, protection and support; strengthening childhood immunization; the prevention and treatment of diarrhoeal diseases; the treatment of ARI; improving vitamin A intake and the universal iodization of salt; addressing protein-energy malnutrition and increasing access to emergency obstetric care and family planning information and services. In those parts of the world where they pose a significant threat to health, additional interventions such as the prevention and treatment of malaria, STDs and HIV/AIDS must necessarily be among UNICEF priorities. The relative importance and mix of these specific interventions are best determined from local situation analyses.

37. Increasingly, UNICEF will seek to address these health priorities in a more integrated manner through strategies that address key immediate and underlying causes of ill-health. This operational framework describes three mutually reinforcing strategies which complement the specific disease-focused approaches to ensure achievement of ambitious health goals in ways that empower families and communities, build national capacity and contribute to sustainable development.

A. Health monitoring, partnership and goals

38. Among the most powerful strategies available to influence public health and guide the action required from decision makers is the measurement of health status, its determinants and the processes which impact on those determinants. All health decision makers require reliable "information for action". Within the household, families need measurable information to identify the faltering growth of a child. Within the community, monitoring processes enable leaders to identify which families have not had access to preventive services. At the national level, monitoring processes enable ministries of health to advocate for policies that promote and protect the public health.

Improving health management information systems

39. The organization and efficient operation of preventive, promotive and curative health services are dependent on reliable health information systems. Health units require ongoing information on the determinants and distribution of specific health conditions within their service area, the community epidemiology, as well as basic information on the availability of supplies and the flow of resources. Required monitoring and analysis include the coverage of outreach services, utilization of clinical services and indicators of service quality. Since the most significant decisions on the utilization of health services are made by families, health monitoring processes also should function to enhance their decision-making capabilities by making readily available the information they require to make health service choices based on quality and cost.

40. From the household through global levels, numerous decisions are made each day that impact on health status and the processes that effect it. The UNICEF nutrition strategy has described the "triple A" cycle of assessing a problem, analysing its causes and taking action based on that analysis. The application of this "triple A" approach in health, as in other sectors, is critically dependent on the accessibility of "information for action" to health decision makers and on their capacity to utilize that information. The following are some key considerations in strengthening health measurement and monitoring for effective action:

(a) Effective health monitoring requires the identification of important health decision makers, especially in the household, the key decisions they make and the minimal information they require to maximally enhance their decision-making;

(b) Health monitoring processes are more likely to be effective and sustainable if they are well understood by health decision makers and if they answer specific questions that can be analysed and acted upon at the level of inquiry;

(c) Participatory measurement approaches are more likely to impact positively on health by involving those who can effect health outcomes within the measurement process. Because of their capacity to motivate, to educate and to link measurement and action, participatory approaches are effective health interventions in their own right, particularly when augmented from time to time by other more rigorous methods;

(d) When community-based monitoring involves local political and social leadership, it is more likely to increase accountability and help to direct attention and resources to those in greatest need;

(e) Sample-based, external monitoring processes such as demographic health surveys can accurately measure health status and its determinants and serve as important measures of society's progress in health. These are essential complements to community-based monitoring systems and can provide helpful information for policy makers and decision makers.

Strengthening the advocacy and quality control capacities of the health sector

41. The effectiveness of the public sector in health - particularly at the central level - will be increasingly dependent on its capacity for advocacy and quality control. Strengthening national-level health sector capacity in monitoring provides the potential for these broader actions to advance public health, both inside and outside the health sector. Within the health sector, partnership between the public and private sectors is often dependent on the public sector's capacity to serve as a monitor of quality and guarantor of equity. For example, while most of the production and marketing of drugs and other key commodities are undertaken by the private sector, it is the public sector that has the responsibility to assure the safety and efficacy of these products.

42. The health sector also has an important role in monitoring the physical environment, including access to safe drinking water, sanitation facilities, air quality and exposure to environmental and safety hazards, both at home and in the workplace. Equipped with ongoing monitoring data and the analysis of the impact of economic, social and industrial policy on child welfare and family health, ministries of health and their partners can serve as strong and vigilant advocates for public health in the broader policy dialogue.

Establishing common goals

43. Clearly articulated, common goals have proven to be essential for fostering a high degree of collaboration among the many independent but mutually reinforcing efforts required to effect social action for health on a broad scale. Commitment to feasible, time-bound goals brings about a sense of urgency and synergism among partners. Common goals also provide a focus for advocacy, an opportunity to mobilize new resources and pressure to shift resources to higher priority undertakings. Ideally, goal-setting processes should exist at all levels and should be guided by a situation analysis of the immediate, underlying and basic socio-economic causes of ill-health. Practically, these processes will need to combine locally identified needs with nationally set priorities based on what are considered epidemiologically relevant, technically sound, economically affordable, culturally sensitive and politically acceptable measures for promoting health action on a large scale.

44. The identification of priorities and opportunities should guide the interdependent processes of partnership-building and establishing common goals.

The Plan of Action of the World Summit for Children stressed the importance of assuring that goals are adapted to the specific realities of each situation "in terms of phasing, priorities, standards and availability of resources. Such adaptation of the goals is of crucial importance to ensure their technical validity, logistical feasibility, financial affordability and to secure political commitment and broad public support for their achievement".

45. Certain goals, such as the reduction of infant, child and maternal mortality, have universal relevance and applicability regardless of culture, economic state or political system. These global goals help to define the "moral minimum" which the international community is capable of achieving within reasonable technical and financial resource limitations. Global goals help to mobilize political will and serve to stimulate partnership-building and goal-setting processes at other levels. The establishment of numerical targets by nations, regions and communities can help to set ambitious but realistic objectives provided they take into account relevant differences in capacities and status. The strategies to achieve even a universally applicable goal will vary considerably in different areas based on community epidemiology, existing cultural and behavioural practices, available resources and infrastructure. While some strategies are widely applicable, the choice and mix of strategies is dependent on an analysis of local epidemiology and other circumstances.

46. The especially rare opportunity to effect the global eradication of a disease presents a special set of circumstances. Only once in world history - with smallpox - has a disease been eradicated successfully from the globe. Polio and dracunculiasis eradication are now technically and programatically feasible. Despite the international political will they can mobilize, disease eradication goals rarely appear among local priorities. Paradoxically, efforts to eradicate a disease require greater levels of national energy and commitment as the disease becomes a less important threat to public health. While the long-term benefits of disease eradication are enormous, the short-term costs of eradication rise substantially as the effort approaches completion, particularly when viewed on a cost-per-case basis. To strike a balance between local priorities and global benefits, eradication efforts can and should emphasize those strategies which reinforce other existing national priorities while simultaneously addressing the disease to be eradicated. Properly designed, such efforts can enhance health sector and community capacities in outreach, disease surveillance and other community-based activities. The global economic benefits of eradicating a disease also should be well appreciated by the global partnership and taken into consideration in extending to developing countries the substantial international cooperation they may require when they join a global eradication effort.

UNICEF action in health monitoring

47. The most substantial contributions of UNICEF in the health sector have been when they have served to build and facilitate strategic partnerships for the health of children, youth and women around well articulated and commonly held goals. The most important health measurement processes required for forging partnerships around goals are those which contribute to ongoing situation analyses of the health of children, youth and women, including the determinants and processes which affect it at every level. While few UNICEF country programmes of cooperation will be in a position to address directly the full array of activities described below, the particular set of interventions they support will be consistent with the approach described.

48. UNICEF programme support through government and NGO partners will need to place greater emphasis on health monitoring processes at household and community levels. Progressively, this will include increased priority to community-based surveillance approaches which engage community political leadership in the monitoring of health status, community health goals and the responsiveness of health services to community needs. Continued emphasis will be placed on the

strengthening of household-level health monitoring, particularly for pregnant women and young children. This includes growth monitoring and promotion, household health records for pregnancy care, immunization, micronutrient supplementation and other significant health events.

49. At the basic health unit level, the principal emphasis in health monitoring will be on those processes which strengthen partnerships between health workers and the community. Particular attention to community outreach will be fostered through strengthening the basic epidemiologic skills of health workers, emphasizing the enumeration of households within service catchment areas and improving the capacities of health units and outreach workers to guide community-based surveillance efforts. Further emphasis will be placed on monitoring the provision of preventive and promotive services throughout the health service catchment area, the quality of services and the allocation and use of available resources.

50. UNICEF will promote practical district-level health monitoring approaches that help to focus the attention of political and social organization leadership and the media on health status, its determinants, the setting of priorities and the progress of local efforts. Priority will be on partnership-building among the health, education and public works sectors in support of community health action. In order to help strengthen quality control capacities at the district level, UNICEF will advocate for processes that monitor utilization of essential services by the most vulnerable within the community. The systematic investigation of maternal and child deaths will be emphasized in order to identify more effective approaches.

51. At the national level, UNICEF will emphasize the strengthening of the health measurement capabilities required to focus political and technical attention and resources on areas of greatest need. This includes support for enhancing the capacities of health ministries and their partners for ongoing situation analyses and advocacy on policies affecting health and the setting and monitoring of specific goals and targets. UNICEF will advocate with global partners to assist ministries in strengthening those capacities required to ensure quality in health services and to protect families from harmful drugs and commercial marketing practices which undermine healthy practices.

52. At the global level, UNICEF will continue to work closely with Governments and other partners to advance the global health monitoring required for advocacy and policy development and to track progress towards the goals of the World Summit for Children. Broader dissemination and utilization of health monitoring information will be encouraged through such instruments as the State of the World's Children report and the Progress of Nations, as well as through expanded relationships with the global media. UNICEF also will continue to work closely with Governments, WHO and other partners to accelerate progress towards the achievement of the World Summit health goals for the year 2000 and the development of common health goals for future decades that will further advance the right of children to health.

B. Health promotion

53. There is a direct and profound linkage between health behaviour and health status. Much of the preventable morbidity and mortality in both the industrialized and developing world can be addressed and mitigated substantially by healthy behaviour. Immunization status, diarrhoeal and other communicable diseases, nutritional status and reproductive health are all substantially influenced by people's behaviour.

54. The principal determinants of health behaviour include a supportive social environment, access to accurate and appropriate information, empowerment skills and peer support. Addressing the determinants of health behaviour is the focus of health promotion efforts. These health promotion efforts seek to enable

individuals and families to make more informed health decisions and to act on them. The major challenge in this effort is to translate health information into the health action required to address the major threats to the health of children, youth and women.

Influencing the determinants of health behaviour

55. Individual health behaviour is linked intimately to community and societal values and practices. The wide range of values and practices with substantial health consequences include community responses to the special needs of new parents and expectant or lactating women; the local norms in breast-feeding and other feeding practices; accepted hygiene standards within the community; health care-seeking behaviour; attitudes towards parenting and child-care responsibilities; expectations that some or all boys and girls will go to school; adult attitudes about sexuality and their correspondence with the practices of young people; economic opportunities available to young women as compared with young men; and marriage age of young women.

56. In many instances the social environment determines people's ability to adopt and maintain healthy behaviour. Laws, policies and influential social institutions have a critical role to play in ensuring that societal values and practices create a positive social environment for achieving good health. The Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women can be especially helpful in finding some sensitive solutions to potentially controversial issues in changing or reinforcing certain types of health behaviour.

57. There is broad agreement on the need to assure that all families have access to the essential health information required to prevent or effectively act on the major threats to health. The challenge is to both assure universal access to information and to relate it to the daily lives of people. Primary prevention information includes knowledge of a healthy household physical environment and preventive health practices such as breast-feeding and hand-washing. It also includes informed demand-creation for high-impact preventive interventions such as immunization and vitamin A supplementation. Home health care information enables families to treat health conditions once they have presented, such as the use of feeding supplements, ORT and interventions that promote prenatal care and safe delivery. Informed health-seeking behaviour requires a basic knowledge of the indications which signify that referral to the health system is required. This is most critical for ARI, severe diarrhoea, complications of child birth and recognizing the symptoms of STDs.

58. The development of empowerment skills is an often neglected element of health promotion efforts. Simply assuring that individuals know what constitutes healthy behaviour does not guarantee that they will either want or are able to adopt that behaviour. Insufficient empowerment skills are linked to a lack of basic education and the low status of women and adolescents in society. Empowerment skills reinforce an individual's self-esteem, confidence and ability to take appropriate action. They include skills in communication, negotiation and decision-making.

59. Individual behaviour is influenced powerfully by the views of family and friends. Negative peer pressure and positive peer support can reinforce attitudes and practices which threaten or promote people's health. Enhancing self-esteem through peer support is the common basis for successful health promotion efforts on several fronts. Peer group interventions combine elements of interpersonal communication, participation and social reinforcement. Peers can provide both the motivation to change behaviour as well as the support and encouragement to maintain healthy behaviour.

60. From the basic health unit to the national level, the health sector must place a greater emphasis on its health promotion function. In many settings, the principal role of the health sector in promoting health behaviour may be to build partnerships with other sectors better placed for influencing community and family practices.

UNICEF action in health promotion

61. The principal objective of UNICEF in health promotion is to encourage, enable and reinforce those individual and societal behaviours most critical to improving the health of children, youth and women. This is approached by addressing the key determinants of health behaviour at multiple levels and in collaboration with different sectors.

62. UNICEF health promotion activities within any country necessarily will be more narrowly focused and less comprehensive than described below. Specific priorities will be determined through the situation analysis and the country programming process. Because health promotion activities often suffer from a lack of rigour in planning and evaluation, clear and measurable objectives and monitoring of the impact of health promotion efforts will be emphasized.

63. Through its programme support, and with its global partners, UNICEF seeks to strengthen the leadership capacities of the health sector in the area of health promotion. This includes its capacity (a) for advocacy in promoting the rights of women, youth and children to health and other basic human needs; (b) to disseminate essential preventive and promotive health information; and (c) for partnerships with interested parties outside the health sector.

64. UNICEF work supports the education sector in the development and implementation of skills-based health education curricula in primary and secondary schools. It also includes support for strengthening the capacities of teachers to better enable them to communicate about health issues and teach age-appropriate health behaviour and skills. Support also is provided for the development of extracurricular programmes in health promotion and community service.

65. A continuing priority for UNICEF is strengthening the capacities of women's organizations for health promotion activities, with a particular focus on community-based groups. This includes support to the incorporation of essential health information into organizations' activities and the creation of peer support mechanisms to motivate health action. UNICEF programme support can facilitate partnerships between women's organizations and the health sector to enable women to voice their opinions on making health services more accessible to them and to carry out joint monitoring of MCH in their communities.

66. UNICEF supports the incorporation of essential health information and skills into the programmes and activities of youth organizations, with a special emphasis on reproductive health, child survival interventions and the development of parenting skills. It provides assistance for training youth to become peer-educator trainers and to establish peer education/support programmes. Creating linkages between the health sector and youth for health promotion and making health services more youth-friendly are being given increased priority.

67. UNICEF works closely with religious institutions and leaders to promote health issues. This includes highlighting their advocacy role in the reinforcement of positive community health norms and practices, including linking religious institutions with the health sector to monitor the occurrence of harmful cultural practices in the community and to advocate for their elimination.

UNICEF supports the creation of mechanisms to improve access of the news
a to health information and story ideas to increase and improve coverage of
th problems, successes and the underlying societal issues which either
ote or hinder public health progress. Particular emphasis will be placed on
ding partnerships between the news media, community groups and the health
or to implement regular media monitoring of health status. UNICEF works
writers and producers in the entertainment media to incorporate health
otion themes into their programming, including those which promote dialogue
debate on sensitive cultural values and issues.

Professional associations of doctors, nurses, pharmacists and other health
essionals are critical partners for UNICEF in ensuring that their colleagues
eminate accurate health information, promote appropriate health practices
provide quality health care. Work with professional associations focuses on
orting their advocacy and assisting in the production of materials and
elines for their membership.

C. Essential health services

All children require preventive health services, and most will require
ical services at some time in their development. Women's needs for health
ices increase substantially with child-bearing. To be viable, health
ices need to include a mix of preventive, clinical and rehabilitation
ices that respond to life threatening circumstances and disease as well as
otive activities that inform and motivate healthy behaviour.

In recent years, particularly in countries experiencing economic
nation or downturns, decreased national spending on public health has
ined sometimes with the inefficient use of already scarce resources to
uce chronic drug shortages, inconsistent services, the deterioration of
th infrastructures, low staff motivation, and, in turn, poor performance and
management. This downward spiral has resulted in a decrease in service
ization, especially by the poor, who increasingly have turned to formal,
rmal and sometimes illegal providers in the private sector for health care.
o doing, they frequently pay high prices for services of dubious quality,
the opportunity to provide vital preventive services is often lost.

Health systems everywhere are in a process of continuous evolution. Where
th systems are faltering, a challenge is presented to Governments,
unities and external agencies to find effective approaches and adequate
urces to reform and revitalize them. Among its major responsibilities, the
ic sector has a fundamental role to act as an agency of greater equity,
ring access, particularly of the poor, to high-quality essential services.
trend towards the decentralization and privatization of health services
s to the increased responsibility of local Governments in the management and
ncing of health services. It also results in increased awareness of the
ate sector potential to play a role in health sector delivery. Where health
ems, public and private combined, are able to deliver basic health services
ctively to the majority of the population, they still must struggle to
re universal access under cost-containment pressures.

No matter where a country falls in terms of the capacity of its health
em, achievement of the World Summit for Children health goals will require
the essential health services needed to address the major causes of
ality among children, youth and women are made universally available.

ciples for effective action

Governments can help to create an environment that is conducive to the
essful provision of health services by promoting policies and approaches
embrace equity, universality of essential services to reduce disparity and
unity participation. These include:

(a) National commitment to and adequate financial support for the development of universally accessible essential health services, which are necessary to achieve health for children, youth and women;

(b) Establishment of health care financing schemes that can be operated at low cost, are adapted to the level of organization and management skills of each country, promote greater equity and increase public accountability and service delivery performance;

(c) Measures, undertaken in close collaboration with local communities, to ensure that the poorest people benefit from quality care and that financial, cultural and geographic barriers are removed;

(d) The provision of adequate resources, management and accountability, and the decentralization of decision-making for the planning and management of public health services, which can greatly improve efficiency and ensure responsiveness to local health conditions and demands;

(e) The privatization of services or contracting out of components of services where the private sector has a comparative advantage, which is desirable if it improves quality, equity and cost-efficiency;

(f) Enhancement of the quality and quantity of health workers' outputs by linking appropriate compensation to performance and by providing health workers with adequate initial training, supervision and continuing education;

(g) The generation by Governments of substantial savings through the setting of essential drugs policies which improve the selection, acquisition and distribution of drugs and encourage their better use. A policy that combines adherence to an established national essential drugs list with the rational use of generic drugs can improve efficiency in the use of resources for health and provide consumers with low-cost treatment.

UNICEF action in essential health services

75. The UNICEF health strategy gives high priority to strengthening the capacities of Governments to ensure that essential health services are universally available to children, youth and women in all countries. The exact involvement of UNICEF in any country setting will depend on the capacity, effectiveness and cost-efficiency of the health system and the interventions of other partners. The weaker the health system, the more likely UNICEF will be involved in its revitalization at community and basic health unit levels, while providing corresponding support to intermediate levels and policy development. The stronger the health system, the more likely UNICEF will limit its involvement to the policy development level in ensuring that essential services are universally available, particularly to the most vulnerable. This requires that UNICEF is cognizant of health system reforms taking place in each country and can serve as an active partner in policy dialogue and in advocating for adequate resource allocations to the health of children, youth and women. Strategies required to ensure universal access to essential health services will be selected according to the particular circumstances within each country.

At the basic health unit level

76. UNICEF views the basic health unit as a "centre of production" where inputs are processed to provide the mix of quality services required by households to help protect their health. While most of the demand is for curative services, which cover the diagnosis and case management of most prevalent diseases, the basic health unit provides an important opportunity for the provision of preventive services and promotive action, examples of which are listed in figure II below. Thus, UNICEF support focuses on strengthening essential curative and preventive services, along with health education

capacity, and outreach services. Health worker training is a major component of this support.

Figure II

EXAMPLE OF ESSENTIAL SERVICES AVAILABLE AT THE BASIC HEALTH UNIT

1. Immunization
2. Prenatal and post-natal care
3. Family planning and STD prevention
4. Correct case management of:
   - Diarrhoea
   - Measles
   - Respiratory infections
   - Tuberculosis
   - Malaria
   - Other priority problems

77. The strengthening of outreach services will continue to be stressed, building on immunization efforts. Alternate approaches to reaching underserved groups will be given high priority in operations research and demonstration activities. This will include the further development of school health service and women's community organization-based approaches. Where health units and outreach cannot provide essential health services, and where community health workers (CHWs) have proven to have an impact in improving health status, UNICEF supports the training and supervision of village-based volunteers and community health workers. Such support emphasizes the provision of continuous and effective supervision to be carried out by the health unit.

78. For health units to be efficient, they require explicit performance objectives, budgets based on clear sources of revenue and managerial autonomy. In most situations in which UNICEF supports the strengthening of basic health units, it also advocates for the involvement of communities in their management, financing and oversight in order to increase provider accountability towards users. Given the important role of women as health providers in the home, the involvement of women in these processes should remain a high priority.

79. UNICEF actively promotes and supports the establishment of community financing mechanisms, especially where there are significant resource gaps that inhibit the proper functioning of local health units and where community financing provides the most equitable and accountable means of generating additional resources. These efforts are guided by the provision that funds generated by community financing remain in the control of the community. UNICEF will continue to advocate that such financing schemes are favourable to the equitable provision of essential services and are accountable to users.

80. Where appropriate, UNICEF may encourage and facilitate consumer groups to expand their roles in influencing and financing health action and services. This may be particularly appropriate in urban and peri-urban areas where the definition of community in geographic terms is less applicable than in rural areas.

At the district level

81. UNICEF advocates for the strengthening of district health systems that support the development of district health plans which include

partnership-building in the provision of essential health services, in collaboration with other sectors. In some settings, support is provided for the strengthening of district health management teams through the training of district managers in the planning, management and monitoring of essential health services.

82. UNICEF also advocates with government and other partners for the effective delivery of essential MCH referral services at the district level and the strengthening of facilities, equipment and health staff with adequate skills to support referral and training functions. Increasingly, UNICEF programme support will expand to include district hospitals as a referral service that provides essential obstetric care and helps to reduce maternal mortality and morbidity. Working with partners, support will be provided for the development of innovative financing schemes to cover the high cost of essential referral services, such as caesarian sections, and to help ensure equitable access to those services.

83. While the primary focus of UNICEF in health has been on supporting the strengthening of rural health systems, the situation of the urban poor will be given increasing attention in terms of their access to, and use of, essential health services. The development of appropriate urban health interventions will be promoted in close collaboration with other institutions, agencies and NGOs.

At the national level

84. UNICEF advocates for an enabling policy framework and the support from the central authorities necessary for basic health units and referral services to assure universal access to essential services. In many countries, this includes contributing to the formulation and expansion of national policies through training, operations research and intercountry exchanges in the areas of strategy development, financing, management and governance.

85. UNICEF will continue to provide strategic support to national programmes in priority intervention areas. Emphasis will be on promoting synergistic approaches to the provision of services that simultaneously reinforce broader public health efforts.

86. Convinced that external resources can help but not replace national financing of essential services, UNICEF will continue to facilitate national self-reliance for essential health commodities by helping countries access low-cost, high-quality products through reimbursable procurement, alternative local currency financing schemes, and, where appropriate, competitive local production. Alternative approaches to the distribution of essential health commodities will be evaluated and supported, including the use of commercial distribution and social marketing.

At the global level

87. Around the world, UNICEF advocates that services for children, youth and women be given priority and that their availability, utilization and impact are monitored globally.

88. Health sector policy reform and the strengthening of health services require close collaboration between Governments and international and bilateral agencies and NGOs. Donor funding is critical to ensure sufficient resources for the universal availability of essential health services until national and local resources are sufficient to meet these needs. UNICEF will continue to work closely with international partners, concentrating its resources on those countries least able to provide essential health services.

IV. ADAPTING TO THE DIVERSITY OF COUNTRY SITUATIONS

89. The unmet priority health needs of children, youth and women vary from one setting to another. Therefore, the scope of UNICEF cooperation in a given country will be more selective than the total broader scope indicated in the present report. Similarly, the mix of strategies also will vary from country to country. While UNICEF advocacy must necessarily be broad, the limited resources at its disposal must not be dispersed in too many areas. The country programming process provides the basis for selecting areas of high priority with the potential for the greatest impact on the health status of children in a given country.

90. The diversity of country situations, based on epidemiology, health infrastructure, social environment, level of poverty and availability of resources, will require that each UNICEF country programme of cooperation follows its own particular mix of health partnership, health promotion and health service strategies. Priority will be given to those approaches which promise the best prospects for the greatest impact on the reduction of child and maternal mortality. The exact nature of UNICEF support will be derived from the situation analysis carried out as part of the country programme exercise. The investments already being made by Governments and other partners obviously will influence decisions concerning UNICEF support. Based on UNICEF experience, some patterns of support emerge in diverse country situations.

91. Countries experiencing an emergency generally require immediate, direct action and operational support to address the most urgent causes of illness and death. In most cases, emergency programmes will be planned and implemented in two phases, with the first focusing on what can be done rapidly to meet the most urgent and immediate health needs of children and women, followed by a second phase focusing on rehabilitating public health services as part of a transition process to long-term programmes.

92. UNICEF responds to emergencies within the framework of its mandate to help meet the emergency as well as long-range needs of children, i.e., to help ensure their survival, protection and development. Working closely with the United Nations Department of Humanitarian Affairs, the Office of the United Nations High Commissioner for Refugees (UNHCR), WHO, the World Food Programme and others, UNICEF will provide assistance to Governments to strengthen their urgent monitoring, communications, planning, coordination and operational support capacities both during and following emergencies. UNICEF general health strategies also are relevant in emergencies, although the range and focus of specific activities may vary.

93. UNICEF will participate in and support rapid, multisectoral assessments to identify the most important threats to the health of children, youth and women, as well as to the population groups at particular risk. It will support the establishment and strengthening of information systems required to monitor health and nutrition status and the coverage and effectiveness of essential health services. Such information is essential to guide emergency response actions and efforts to rehabilitate public health systems.

94. UNICEF will provide support to help ensure the maintenance, re-establishment and/or extension of essential health care services, as required. This may include (a) assistance in supplies management and training and in positioning sufficient quantities of essential supplies at the right place and time, with special emphasis on re-establishing cold-chain operations, medical stores and distribution systems and on assuring supplies of vaccines, essential drugs and related supplies; (b) critical rehabilitation of PHC facilities, where necessary, to assure a necessary minimum level of functioning; and (c) supervision, training and related support for health workers, as well as training for local-level health managers.

95. While assistance will be focused on supporting PHC services, including immunization services, community-based distribution of vitamin A and oral rehydration salts (ORS) and ensuring essential obstetric care, some assistance may, in a major emergency, also be provided to ensure the general functioning of district hospitals, in close coordination with WHO and other health agencies. Where it constitutes an important need, UNICEF will provide assistance to the strengthening of prosthetics and community-based rehabilitative services for disabled children, working with government services, NGOs and other partners.

96. Interventions for health promotion and communications are particularly critical in the rapidly changing circumstances of an emergency. UNICEF will support health communications activities, with a particular emphasis on personal hygiene behaviour and home health practices. This will include support to prepare and distribute essential health and nutrition information materials and the use of all appropriate communications channels, including television and especially radio.

97. In instances where the public health system has been totally disrupted, the major priority of UNICEF, working closely with WHO, will be to help re-establish appropriate public health services structures and management, and, in the interim, to facilitate coordination among the various organizations providing urgent services. This may include guiding and assisting NGOs to meet the priority needs of children and women, while developing local capacity and establishing a basis for sustainable services in the future.

98. In countries with weak economies and a weak health sector, UNICEF supports the provision of essential health services for children, youth and women through support to national programmes, as well as through assistance for revitalizing peripheral health care facilities. Key operational support is provided at the district level so that training and supervision activities take place. Health promotion efforts focus on essential nutrition and disease prevention information and skills, along with improved health care-seeking behaviour. Health monitoring priorities include the assessment of service coverage, disease reduction and other management information required to assure efficient use of scarce health resources and to enhance community involvement.

99. In countries with adequate health infrastructure, greater emphasis is placed on the health partnership and promotion aspects of the UNICEF health strategy, along with support to first referral services and increased attention to quality care issues. Emphasis also is placed on vulnerable populations and geographic areas with high child mortality. In these settings, UNICEF advocacy encourages the creation and strengthening of partnerships for sustainable multisectoral approaches to health and greater emphasis on the underlying causes of ill-health.

100. Countries in economic transition require more narrowly focused support in each of the three strategic areas. Health partnership development and health status monitoring are most critical. These enable societies to be informed of negative health trends and to create a better understanding of the implications for health of policy development in other sectors. In its cooperation, UNICEF will seek to introduce new approaches that are less hospital dependent and more prevention-oriented, and that build on successful experiences elsewhere in such areas as the adoption of essential drug policies.

101. In countries with strong economies, UNICEF efforts are oriented principally towards advocacy, with particular emphasis on ensuring that health promotion and essential health services reach the most vulnerable groups in society. Partnerships and monitoring focus on supporting goal-setting processes and the quality control of health services and promotion efforts.

V. KEY PROGRAMME STRATEGIES

102. The present health strategy paper incorporates key observations made by the 1992 multi-donor evaluation of UNICEF. It places a high priority on identifying partnership opportunities at national and local levels with governmental and non-governmental institutions; establishes a framework for greater policy coordination and increased technical dialogue with other United Nations partners; and proposes greater UNICEF involvement in addressing the underlying causes of ill-health and malnutrition. It also seeks to strike a practical balance between advocacy efforts, which address the many important multisectoral determinants of health, and programming efforts focused on a smaller number of strategic interventions that address the major causes of preventable disease. The health monitoring, promotion and essential service strategies proposed reflect a mix of support to the delivery of specific services, capacity-building for sustained programme delivery and empowerment of families and communities, with a special focus on children, youth and women.

A. Improvement and expansion of essential services

103. Meeting the health needs of children requires establishing the universal availability of a basic set of preventive interventions, promotive activities and clinical services of acceptable quality that have a direct bearing on the reduction of child and maternal mortality and morbidity. Disparity reduction and attention to the neediest have to be key considerations for UNICEF as it promotes the universalization of basic services. The key strategies in expanding and improving the quality of services with disparity reduction are (a) programme designs aimed at reaching and serving all, especially those most in need; (b) training and motivation of health workers to be able to deliver a basic package of key services; (c) involvement of the community in the management of services for great appropriateness and convenience of services to consumers; and (d) ensuring the continuous availability of basic inputs, including knowledge and information, vaccines, drugs, medical supplies and transportation arrangements for urgent referrals.

B. Capacity-building at different levels

104. Service delivery and health action cannot be achieved effectively without adequate capacity-building efforts. Increasing decentralization in public administration worldwide means that the capacity-building efforts should be focused primarily at subnational and local levels. Therefore, strategies need to be geared towards (a) sustained development of human resources to maintain skilled front-line workers, medical personnel and supervisors and to foster community groups able to manage services and promote local health action; (b) the strengthening of subnational health management teams with adequate skills in the planning and management of people, finances and information, and supported with adequate levels of financial resources and commodities to run the local health system; (c) involvement of the community in the management of services; and (d) ensuring the continuous availability of basic inputs, including knowledge and information, vaccines, drugs, medical supplies and transportation arrangements for urgent referrals.

C. Empowerment

105. Key decisions concerning the health of children and women are made in the household. Therefore, achieving informed decision-making on health in the home, on improvements in the household environment and on the best use of available health care requires (a) communication that makes knowledge of health, causes of ill-health and ways to improve individual and household health behaviour universally available, including the rational use of health commodities such as ORS and drugs; and (b) the development of consumer organizations, particularly women's groups, that have common health interests and can collectively raise awareness of health needs and promote appropriate action. The mass media,

schools, agricultural extension workers, religious institutions and NGOs, as well as the health services, should become the facilitators and promoters of empowerment and the sources of information and knowledge for families, communities and the public.

D. Social mobilization and policy advocacy

106. Health and health sector development geared to children and women need to be situated within a conducive policy environment. This requires strategies that include (a) consensus-building, mobilization, motivation and orientation of key stakeholders at all levels and in different sectors of the society for greater commitment to children's and women's health; (b) ensuring that health sector reforms give priority to the needs of children and women; and (c) developing legislation and regulatory mechanisms, such as essential drugs policies, decentralization and local retention of resources, that increase the effectiveness of the health system to provide a universal basic package of services.

E. Attention to cost-effectiveness

107. Resources for health are limited everywhere, and attention to cost-effectiveness is critical. This applies equally to the main sources of funding for health, i.e., governmental, external, philanthropic and household. Strategies for greater cost-effectiveness include (a) definition of a basic package of services, based on proven cost-effective technologies, such as immunization, oral rehydration, use of generic-name essential drugs, and seeking out, as much as possible, low-cost and high-impact interventions; (b) advocating for the shift of government resources to the provision of the basic package of services, with an emphasis on those parts of the package geared specifically to public health; (c) increasing efficiency in the use of available resources, particularly at the local level, through informed management based on attention to costs and benefits of services; and (d) assisting households to receive optimal benefits from their expenditure on health through better information and access to the basic package of services.

F. Sustainability of programmes

108. Longer-term sustainability of health programmes has political, economic, technological, administrative and institutional dimensions. Ensuring sustainability of programmes, even when external assistance ceases, will require attention to:

(a) Designing and adapting programmes to ensure that they meet criteria of universality and equity and address critical health needs of people, and, thus, continue to command the support of beneficiaries and other important stake-holders;

(b) Building necessary skills and capacities as well as organizational and management structures, making these sufficiently participatory so that the programmes are run effectively and concerned parties "own" them;

(c) Developing an adequate base of resources, tapping different sources including the Government, the community, the private sector and the household, and using cost-effective approaches so that programmes ultimately rely on indigenous resources;

(d) Using technologies that are proven, cost-effective and do not perpetuate external dependency.

VI. CONTINUING AND EMERGING PRIORITIES FOR UNICEF

A. Continuing priorities

109. UNICEF will continue to give priority to those major programme areas in which its cooperation has been most effective in recent years and that address the major causes of infant, child and maternal mortality. Achievement of the World Summit for Children goals for the year 2000 will continue to enjoy a high priority in UNICEF programme cooperation and advocacy. Appropriate adjustments will be made in the types of assistance provided, as countries build capacities and move towards greater self-sufficiency.

110. Support for the provision of basic preventive and curative services for children will be aimed at ensuring universal availability of a sustainable package of such services. Support for immunization will be geared to reach and sustain coverage levels of at least 90 per cent of children under one year of age and to eliminate neonatal tetanus, control measles and eradicate polio by the year 2000. This will require improving the quality of services, ensuring safe injection practices, enhancing management capacity, assisting with national self-sufficiency in the provision of vaccines, and supporting improved disease surveillance, monitoring and evaluation. UNICEF will strive to utilize the special activities for polio eradication as a tool to improve national capacity for surveillance, targeting immunization activities and reaching at-risk populations, and breaking the chains of disease transmission. Greater emphasis will be placed on building upon the outreach of immunization to deliver a broader set of interventions, such as vitamin A and iron/folate supplementation, in a cost-effective manner. National strategic vaccine planning, with a focus on self-sufficiency with support of the Vaccine Independence Initiative financing mechanisms, will allow UNICEF to assist actively with the introduction of new and improved vaccines, generated through CVI, into national programmes. These vaccines may eventually include hepatitis B, where appropriate, as well as other new and improved vaccines against respiratory and diarrhoeal diseases and malaria. UNICEF procurement strategies are being developed to take advantage of economies of scale and technological developments to reduce costs and assure affordability of new vaccines for the poorest countries.

111. Continued emphasis will be placed on the rationalization of case management approaches to sick children, particularly against the major causes of mortality which include pneumonia, diarrhoea, measles and malaria. UNICEF advocacy and programme support will emphasize early case detection and referral by families and CHWs following initial treatment, where appropriate; strengthening technical capacities of health workers in syndromic approaches to diagnosis and therapy; improved secondary referral where feasible; and improved access to essential drugs.

112. UNICEF will continue to support the strengthening of health promotion and improved home health practices. Breast-feeding promotion continues to rank among the most important nutritional support and disease prevention strategies for infants and young children. Continued emphasis on breast-feeding and other sound nutritional practices, hand-washing and appropriate sanitation practices can have a major impact on reducing the incidence of diarrhoeal diseases. Intensified efforts to promote ORT and its proper usage for the home-based treatment of diarrhoeal diseases can reduce substantially associated morbidity and mortality. The household prevention of malaria will be assisted through support to impregnated mosquito bed-net distribution, presumptive therapy in children and measures to reduce mosquito breeding around the household. Knowing when to seek health care outside of the household for ARI, diarrhoeal diseases, malaria and other health problems, as well as for preventive services such as immunization and vitamin A supplementation, will continue to receive high priority from UNICEF.

113. UNICEF will continue to place particularly high priority on addressing the major causes of preventable disability in children. Continued assessment of iodine and vitamin A deficiency will play an important role in identifying areas where actions should be undertaken to eliminate these deficiencies which are, respectively, the major causes of mental retardation and blindness among children. Together with other partners, UNICEF will support global efforts to eradicate two crippling diseases of children - polio and dracunculiasis - while utilizing these efforts for improving national and community capacities for surveillance of other diseases and for extending health outreach activities to remote and at-risk populations.

114. Increasing the availability of essential drugs and other supplies is critical in several programme areas. UNICEF will assist those countries requiring support to ensure the availability of affordable essential drugs to treat ARI, chronic diarrhoea, STDs, malaria and other important causes of morbidity and mortality. Safe motherhood interventions may include assuring that first referral hospitals are equipped with the necessary supplies and instruments required for emergency obstetric care.

B. Emerging priorities

115. The rapidly changing circumstances in countries and the opportunities to build on public health progress highlight the need to focus greater attention in several key areas, including women's health. ICPD has underscored the intimate link between women's status in society and their reproductive health decisions and actions. There is now wide consensus on the need to view family planning in the broader context of women's empowerment and their reproductive health. The Conference has helped to bring important aspects of women's health to the forefront. In particular, strategies and interventions in reproductive health should be strengthened and complemented by efforts to promote girls' education and gender equity in households, communities and societies. The ICPD Plan of Action reinforces the need for UNICEF to pursue vigorously policies enunciated in recent reports to the Executive Board papers on family planning (E/ICEF/1993/L.5), safe motherhood (E/ICEF/1990/L.13), HIV/AIDS (E/ICEF/1992/L.11) and gender equity and empowerment of women and girls (E/ICEF/1994/L.5). The report on the UNICEF role in the follow-up to ICPD (E/ICEF/1995/12) offers additional specific guidance for UNICEF action in this context.

116. The overarching goal for the reduction of maternal mortality can be achieved by identifying and integrating reinforcing strategies through national and local priority-setting processes which will be guided by the goals set in the ICPD Programme of Action. Measurement will focus on community investigation of maternal deaths and on the underlying social indicators which influence women's health. Health promotion interventions will build close partnerships with women's organizations to communicate essential health information, teach skills and provide peer support and motivation for healthy behaviour. This is especially critical for the prevention of HIV/AIDS and other STDs as well as for family planning promotion.

117. Within the health sector, UNICEF programming for women's health will aim at developing and strengthening a set of essential services for pregnancy care at the local level, universal access to skilled nurse/midwives for delivery and access to emergency obstetric care at district hospitals. UNICEF support to improving access to family planning information and services will continue to be carried out in close cooperation with UNFPA as an important intervention towards improving maternal survival and well-being.

118. Young people, particularly adolescents, have unique physical and psychological qualities that mark their transition from children to adults. Their health and development during adolescence has significant impact on their health as adults, on their capacity to be caring parents and on the health of

their children. Their needs and problems - especially in the areas of sexuality, substance use and other high-risk behaviour - require special attention. UNICEF programming for youth health will focus on a cluster of health problems that have common roots, interact with one another in terms of cause and effect, and contribute significantly to child and maternal mortality. Most important among these are unsafe sex, substance abuse, poor nutrition and violence.

119. The principal emphasis in youth health will be on the promotion of healthy decision-making and action. It is during childhood and adolescence that people establish life-long attitudes and practices regarding their health and development. Therefore, it is crucial to provide youth with information and skills to make healthy decisions for themselves and their future families. Promoting youth health and development requires working with schools to develop integrated health education programmes, working with health systems to provide youth-friendly services and working with youth organizations to incorporate health promotion into their programmes and team-building activities. Measurement and monitoring priorities in adolescent health, especially in the area of reproductive health, will include emphasis on age-disaggregated data.

VII. IMPLICATIONS FOR UNICEF

120. Perhaps more than in any other sector, UNICEF has a proven track record of effective cooperation in the health sector. Developing countries find the modalities of UNICEF cooperation responsive to their needs, and donors and other partners of UNICEF in health have long recognized that UNICEF cooperation is producing significant results with modest resources. The multi-donor evaluation of UNICEF in 1992 recognized that UNICEF was "unusually well equipped with human and financial resources and with different means of intervention, including advocacy, technical programme assistance, and provision of supplies and inputs".

121. The health strategies discussed in the present report do not call for any significant changes in the modalities of UNICEF cooperation. As discussed in paragraphs 109-119 above, there will be a great degree of continuity in areas of UNICEF cooperation, while some new and emerging areas of priorities will be added selectively. However, the strategies discussed in the present report offer an opportunity for UNICEF to refine some of its processes for even greater effectiveness in its cooperation.

122. Multisectoral situation analyses of health status will need to place greater emphasis on measuring the status of health partnerships, promotion efforts and utilization of essential health services, highlighting their link to key epidemiological factors. Disparity reduction objectives will require greater emphasis on the identification and characterization of vulnerable populations and the strengthening of data and information management capacities required to support situation analyses at subnational levels.

123. Within the health sector, UNICEF will need to increase capacities and focus on the analysis of underlying causes of mortality and morbidity. Analysis and planning for women's health, especially maternal health, will need to be intensified, with attention given to more rigorous assessment of the immediate, underlying and basic socio-economic causes of maternal mortality and morbidity. Current experience in this area needs to be evaluated and developed into strategies that can be implemented on a large scale.

124. Improved situation analysis capacities will provide a basis for strengthening information-based advocacy at the national level, building on the examples of the State of the World's Children and Progress of Nations reports. Increased emphasis on health sector evaluation and operations research will move UNICEF offices a step closer to serving as "knowledge centres for children" at country, regional and global levels.

125. External to UNICEF, relationships with Governments at the national level are more likely to emphasize health measurement, partnerships with national technical agencies and collaborating international and bilateral agencies, and priority-setting processes. Relationships at the subnational level are more likely to emphasize the strengthening of implementation partnerships with NGOs.

126. Within UNICEF, enhanced collaboration among the areas of nutrition, education, water supply and sanitation, gender and development, children in especially difficult circumstances, information, emergencies, supply, and evaluation and research will enhance the multisectoral approach to health that UNICEF is in a unique position to foster.

127. Particular efforts will be required to rationalize the common types of inputs and processes needed to address simultaneously multiple priority problems. A more integrated approach to training, information and logistics systems will be fostered in implementing priority health actions. Where appropriate, this will build on the successful though more narrowly-focused systems that have been developed during past years.

128. To achieve these ambitious objectives, UNICEF requires a more cohesive and interactive core technical capacity in health at country, regional and headquarters levels, supported by a shared technical capacity built on a partnership basis among national institutions, as well as United Nations bilateral organizations. The organization's cadre of approximately 200 international health professionals is insufficient to provide all the technical inputs required of increasingly complex programmes in over 130 countries. However, if appropriately networked, this cadre provides a solid base for a much broader shared technical capacity with partners in the health sector, especially WHO, UNFPA and technical divisions of bilateral organizations. Mechanisms to provide state-of-the-art technical information to staff at country offices is of great urgency and should be facilitated through existing networks, both institutional and electronic, as well as through continued efforts to strengthen operational linkages with WHO. Mechanisms between UNICEF and other major donors and institutions that can share and acquire technical capacity will need to be encouraged. Through strategic institutional partnerships, staff exchanges, secondment and ongoing technical networking, UNICEF country programmes can benefit from and provide an effective platform for technical resources deployed by other agencies, in particular, bilateral agencies and their national technical partners.

129. At the regional level, the main function will be one of technical strategy development and related support to countries through building partnerships with international and bilateral agencies, regional institutions and technical networks. The principal functions at the headquarters level are ongoing policy development, global partnership-building and quality control activities that assess UNICEF investment in countries to facilitate interregional experience sharing and ensure appropriate application of policies.

130. In its operations, UNICEF will continue to be a significant partner in supplying those key health commodities in countries that facilitate household health action and help to ensure the quality of essential health services. More emphasis will be required on supporting countries in achieving greater independence in acquiring commodities through innovative financing mechanisms and through economies of scale in the global market place. The Vaccine Independence Initiative and the Essential Drugs Capital Fund have been essential actions in supporting countries with these essential commodities, especially in the face of foreign currency difficulties. Such schemes will have to take an even more prominent place and be expanded to include other key commodities used in essential health services and directly by households.

131. UNICEF financial procedures require greater flexibility in order to enable actions such as stockpiling essential health commodities and multi-year

contracting of vaccines and drugs for the purpose of price stabilization and to facilitate rapid and timely provision to countries.

132. In countries with weak public systems, UNICEF will require the flexibility to work with partners in establishing mechanisms to generate community funds that are invested in health, particularly in the provision of essential drugs and other commodities for replenishment at the community level. Funds-in-trust mechanisms will require assessment and streamlining in order to accomplish this role effectively. In some circumstances, these mechanisms are the only recourse poor communities have for using their own resources for purchasing essential health commodities.

133. Assuring achievement of the World Summit for Children health goals will require that significantly more financial resources are generated through UNICEF and its partners. UNICEF will need to develop a stronger capacity to advocate and fund-raise around specific goals, while programming in a more integrated fashion.

VIII. DRAFT RECOMMENDATION

134. The Executive Director recommends that the Executive Board adopt the following draft recommendation:

The Executive Board,

Having reviewed the report on the health strategy for UNICEF, (E/ICEF/1995/11),

Noting with satisfaction UNICEF efforts to assist countries to achieve the 1990s goals for children by implementing national programmes of action and encouraging progress towards reaching the mid-decade goals and targets;

1. Endorses the framework for programmes, the scope, objectives and areas of action, as well as programme strategies for health presented in the report;

2. Encourages UNICEF to continue:

(a) To give high priority to support programmes aimed at controlling and preventing diseases and health conditions that are major causes of death and disability among children, youth and women and for which cost-effective strategies exist;

(b) To promote a partnership of Governments, civil society and households to meet the health needs of their children, youth and women, with an emphasis on enabling households to take health action, creating a supportive social environment for health and monitoring health status, its determinants and processes;

(c) To adapt global health goals and strategies for children and women to the diversity of country situations based on epidemiology, the development of health structures, socio-economic conditions and environmental features;

(d) To promote, with national and international partners, cost-effective approaches to ensure universal, equitable and sustainable access to essential health care services for children;

(e) To focus, in emergency situations, on children's and women's essential health needs within the framework of the response of the United Nations system to emergencies;

3. Urges UNICEF to put a greater emphasis in its programmes on:

(a) Participating actively in advocacy, analysis and dialogue to promote appropriate national policies, priority-setting and resource allocations for meeting the health needs of young children, youth and women;

(b) Addressing women's health needs - focusing on safe motherhood, reproductive health and the capacity of women to make informed health choices - and relating these efforts to the broader objective of improving women's status in society;

(c) Promoting youth health and development as an important approach for enabling people to protect and promote their own and their children's health and for addressing youth health problems, including reproductive health, substance abuse and violence;

4. Requests the Executive Director to assess and adopt measures necessary to strengthen UNICEF capacities to play its role effectively in promoting the health of young children, youth and women in the changing global context.

Annex I

RECENT DOCUMENTS SUBMITTED TO THE EXECUTIVE BOARD RELATED TO THE UNICEF HEALTH STRATEGY

Reference	Subject
E/ICEF/1990/L.3	Revitalizing primary health care/maternal and child health: the Bamako Initiative
E/ICEF/1990/L.5	Development goals and strategies for children: priorities for UNICEF action in the 1990s
E/ICEF/1990/L.6	Strategy for improved nutrition of children and women in developing countries
E/ICEF/1990/L.13	Safe motherhood
E/ICEF/1991/P/L.41	Establishment of a vaccine independence initiative
E/ICEF/1992/L.7	UNICEF health policies and strategies: sustainability, integration and national capacity-building
E/ICEF/1992/L.11	UNICEF programme approach to the prevention of the human immunodeficiency virus/acquired immunodeficiency syndrome
E/ICEF/1992/L.12	Controlling acute respiratory infections: strategies for the 1990s
E/ICEF/1992/L.20	Experience to date of implementing the Bamako Initiative: a review and five country case studies
E/ICEF/1993/L.2	Children, environment and sustainable development: UNICEF response to Agenda 21
E/ICEF/1993/L.3	Progress report on the Children's Vaccine Initiative
E/ICEF/1993/L.5	UNICEF policy on family planning
E/ICEF/1993/L.10	Progress report on UNICEF programme activities in the prevention of the human immunodeficiency virus and in reducing the impact of acquired immune deficiency syndrome on families and children
E/ICEF/1994/3	Medium-term plan for the period 1994-1997
E/ICEF/1994/L.5	Gender equality and empowerment of women and girls: a policy review
E/ICEF/1994/L.14	UNICEF support to the proposed United Nations joint and co-sponsored programme on human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS)
E/ICEF/1994/L.15	Human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) programme

Annex II

SELECTED HEALTH GOALS ENDORSED BY THE WORLD SUMMIT FOR CHILDREN

I. Major goals for child survival, development and protection

(a) Between 1990 and the year 2000, reduction of infant and under-five child mortality rates by one third or to 50 and 70 per 1,000 live births, respectively, which ever is less;

(b) Between 1990 and the year 2000, reduction of maternal mortality rate by one half;

(c) Between 1990 and the year 2000, reduction of severe and moderate malnutrition among under-five children by one half;

(d) Universal access to safe drinking water and to sanitary means of excreta disposal;

(e) By the year 2000, universal access to basic education and completion of primary education by at least 80 per cent of primary school-age children;

(f) Reduction of the adult illiteracy rate (the appropriate age-group to be determined in each country) to at least one half its 1990 level, with emphasis on female literacy;

(g) Improved protection of children in especially difficult circumstances.

II. Supporting health goals

A. Women's health and education

(i) Special attention to the health and nutrition of the female child and to pregnant and lactating women;

(ii) Access by all couples to information and services to prevent pregnancies that are too closely spaced, too late and too many;

(iii) Access by all pregnant women to prenatal care, trained attendants during childbirth and referral facilities for high-risk pregnancies and obstetric emergencies.

B. Nutrition

(i) Reduction of iron deficiency anaemia in women by one third of the 1990s levels;

(ii) Virtual elimination of iodine deficiency disorders;

(iii) Virtual elimination of vitamin A deficiency and its consequences, including blindness;

(iv) Empowerment of all women to breast-feed their children exclusively for four to six months and to continue breast-feeding, with complementary food, well into the second year.

Annex II (continued)

c. Child health

(i) Global eradication of poliomyelitis by the year 2000;

(ii) Elimination of neonatal tetanus by 1995;

(iii) Reduction by 95 per cent of measles deaths and reduction by 90 per cent of measles cases, compared to pre-immunization levels, by 1995, as a major step towards the global eradication of measles in the longer run;

(iv) Maintenance of a high level of immunization coverage (at least 90 per cent of children under one year of age by the year 2000) against diphtheria, pertussis, tetanus, measles, poliomyelitis and tuberculosis and against tetanus for women of child-bearing age;

(v) Reduction by 50 per cent in deaths caused by diarrhoea in children under the age of five years and 25 per cent reduction in the diarrhoea incidence rate;

(vi) Reduction by one third in deaths caused by acute respiratory infections in children under five years of age.

Annex III

KEY HEALTH PROVISIONS IN THE CONVENTION ON THE RIGHTS OF THE CHILD

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children and emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate prenatal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to health of children.

4. States Parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.